2025 Oregon Large Group Employee Enrollment/Change Form

Please print in black or blue ink only.

KAISER PERMANENTE®

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest. 500 NE Multnomah St., Suite 100, Portland, OR 97232.

Employer section (To be completed by the employer. Subgroup and billgroup information required if coverage is selected.)

Company name[1] _____ Effective date of coverage[1] ____/____/____

Multnomah Bar Association Plan Selection: Gold____ Gold PPO____ Silver____ Bronze____ Bronze H.S.A. ____

Add Dental To Medical Plan ☐☐ Kaiser Dental Only (no Kaiser Medical) ☐☐ **ATTORNEY OSB #** _____ (Enter 6 digit #)

Enrollment/change reason — complete if existing group[1] *(Please check one.)* Hire date ____/____/____

☐ New hire ☐ Newborn ☐ Loss of coverage ☐ Part-time to full-time ☐ Change _____

☐ Open enrollment ☐ COBRA ☐ State continuation ☐ Other/qualifying event _____

Does the subscriber live or work inside the Kaiser Permanente Northwest service area? ☐ Yes ☐ No

A Employee information (Employee completes sections A, B, and C.)

Select benefit type:[1] ☐ Medical _____ (plan choice) ☐ Dental _____ (plan choice)

Legal name ***(last, first, MI)***[1] _____

Former/maiden name ***(if any)*** _____ Date of birth[1] ____ / ____ / ____ Social Security no. _____

Sex[1] ☐**M** ☐**F** ☐**X** ☐Decline to provide (at this time) Preferred pronoun(s) _____

Home address[1] _____ Apt. _____

City _____ State ____ ZIP _____ Email _____

Mobile phone _____ Home phone _____

Health record no. ***(if any)*** _____ Preferred language _____

B Dependent information (For additional dependents, please use our Addendum to Oregon Group Employee Enrollment/Change Form. If this is for additions of dependents, please include all dependents whom you want to remain on the plan after the change effective date.)

Select one: ☐ Spouse ☐ Spouse/registered domestic partner[2] ☐ Non-registered domestic partner

Legal name ***(last, first, MI)***[1] _____

Date of birth[1] ____/____/____ Social Security no. _____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Preferred pronoun(s) _____ Mobile phone _____ **Disabled** ☐ **Yes** ☐ **No**

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. ***(if any)*** _____

Dependent (child) legal name ***(last, first, MI)***[1,3] _____

Date of birth[1] ____/____/____ Social Security no. _____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Preferred pronoun(s) _____ Mobile phone _____ **Disabled** ☐ **Yes** ☐ **No**

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. ***(if any)*** _____

Dependent (child) legal name ***(last, first, MI)***[1,3] _____

Date of birth[1] ____/____/____ Social Security no. _____ Sex[1] ☐ M ☐ F ☐ X ☐ Decline to provide (at this time)

Preferred pronoun(s) _____ Mobile phone _____ **Disabled** ☐ **Yes** ☐ **No**

☐ Medical ☐ Dental Other health insurance ☐ Yes ☐ No Insurance co. _____

Policy no. _____ Health record no. ***(if any)*** _____

☐ Check here to add additional dependents and attach the Addendum to Oregon Group Employee Enrollment/Change Form. Include employee name and Social Security number on form.

[1] Required

[2] A person who is legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your employer. [3] Eligible through the last day of the month of their 26th birthday month or for dependent children over the age of 26 with a developmental or physical disability.

Per state law, if children of the insured employee are covered, children of state registered domestic partners are covered on the same basis. If your employer chooses to provide coverage for non-state registered domestic partners, and children of the insured employee are covered, children of non-state registered domestic partners are covered on the same basis.

C Important — Your application cannot be processed without your signature. Please read the entire form before signing.

If you make an intentional misrepresentation of material fact through misstatement or omission, Kaiser Foundation Health Plan of the Northwest (KFHPNW) may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. Applicant must promptly inform KFHPNW in writing if anything happens before coverage takes effect that makes the application incomplete or incorrect. It may be a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits. I acknowledge by my signature that the information I have supplied on this form is true and correct and that I have read and agree to the requirements, terms, conditions, limitations, and provisions described on this form.

Employee signature[1]_____ Date____/____/ ____

Please read the following before signing your form

The following statements are valid for the period of coverage I have selected under this plan for myself and my current and future dependents who are or will be covered, unless I or my dependents provide written notification of a change.

- I hereby acknowledge, on behalf of myself and my enrolled family members, that Kaiser Foundation Health Plan of the Northwest (KFHPNW) may request personal health information, including information regarding treatment or services that any of us may receive from a physician, health care practitioner, hospital, medical office, or other medical facility. I also acknowledge that KFHPNW or its authorized designee may use and disclose such personal health information for treatment, payment, or health care operations without authorization in accordance with applicable law. This is not an authorization for the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- I allow the proper deductions, if any, to be made from my earnings as my part of the cost of this coverage.

Member rights and responsibilities

For more information about Kaiser Permanente member rights and responsibilities, go to **kp.org/disclosures** and select "Oregon/SW Washington" from the pull-down menu.

Submitting the enrollment application

This enrollment form is to be submitted by the employer. Please be sure the form is complete and includes the employee's signature. Missing or incomplete information may significantly delay the enrollment process.

By mail:
MBA Health Plans
PO Box 12263
Salem, OR 97309

By fax:[2]
503-589-9399

By email:
ALB-Enrollment@alliant.com

Plan details, including all benefits, exclusions, and limitations, are provided in the ***Evidence of Coverage (EOC).*** To get an ***EOC*** for a particular plan, contact Member Services. In the event of any conflict between this brochure and the ***EOC,*** the ***EOC*** prevails.

[1]Required
[2]Please limit fax submissions to one enrollment form per transmission.

KAISER PERMANENTE®

How to fill out this form

1. Please print legibly in black or blue ink.
2. To be enrolled, you must live or work within the Northwest service area at least 50% of the time, unless you are enrolling in Dual Choice PPO™, Added Choice®, or PPO Plus®. To enroll in PPO Plus, you must live and physically work outside the service area.
3. Your employer must complete the employer section. Your employer is responsible for confirming all information before submitting this form, especially effective dates, as these affect your premium.
4. You must complete sections A through C. In section A, fill out information about yourself. Fill out section B if you are enrolling any dependents. Be sure to include any former last names for dependents. Read section C and the entire form. Then sign and date the form.
5. If this is a change in enrollment such as adding a dependent, complete all sections and include all dependents to be covered as of the effective date of the change.
6. Once the form is complete, make a copy for your records. (You will soon get a Kaiser Permanente ID card.)

All effective dates will be made in accordance with the contractual agreement between the group (your employer) and Kaiser Foundation Health Plan of the Northwest.

Member Services

Monday through Friday, 8 a.m. to 6 p.m.

1-800-813-2000

or

1-866-616-0047 for Dual Choice PPO, Added Choice, and PPO Plus members

For TTY, call **711.** For language interpretation services, call **1-800-324-8010.**

FOLGENRL0121

Get connected

Follow the simple steps on the left side of this page to enroll in your plan.

I'm a new member!

Your ID card

You will soon receive a Kaiser Permanente ID card containing your name and unique 8-digit health record number. You'll want to have this card handy when you call for an appointment, speak to an advice nurse, or come to us for care. If you don't have your ID card before your first appointment, bring your photo ID. Once your ID card is issued, you can access a digital copy on the Kaiser Permanente app.

Choose your doctor — and change anytime

Go to **kp.org/newmember** to browse our doctor profiles and find a doctor who matches your needs. Once you've chosen, call the New Member Welcome Desk at **1-888-491-1124** to schedule your first appointment. For TTY, call **711.**

Transfer your prescriptions

If you have prescriptions to transfer, you'll want to fill out the Transfer Your Prescriptions form at **kp.org/newmember** right away, or you can contact the New Member Welcome Desk at **1-888-491-1124** for help. Usually you can receive a one-time refill of a prescription written by a nonparticipating or out-of-network provider if the medication is on our formulary and your prescription allows for refills.

Register at kp.org

Enjoy around-the-clock, secure access to care with online features that can save you time and money. Once you are registered, you can email your doctor's office, view most lab results, refill prescriptions, schedule routine appointments, and much more. Go to **kp.org/register** to get started. You'll need your 8-digit health record number on your ID card to register.

KAISER PERMANENTE®